were made on dogs, rabbits, and white mice. In the histological preparations no effect whatever of the fibrolysins could be found. The lymphogogue effect of the fibrolysin is at the present time doubtful. From the fluctuation in the number of leukocytes found, the fibrolysin is not shown to be a specific means of producing a leukocytosis. The therapeutic dose is harmless and produces no favorable appearances. From a critical examination of the material of other authors and of his own, the clinical and experimental evidence allows the assertion to be made that fibrolysins do not exert a therapeutic effect upon cicatricial tissue.

Thrombosis of the Cavernous Sinus not of Otitic Origin.—Otto (*Deut. Ztschr. f. Chir.*, 1911, cx, 177) says that thrombosis of the lateral sinus is frequently of otitic origin, and rarely arises from a surface infection with a thrombophlebitis progressing into the cranial cavity. He reports a case in which a carbuncle of the back of the neck gave rise to a septic thrombosis of the cavernous sinus which was demonstrated at autopsy. From his study of the subject he concludes that the cause of the thrombosis of the lateral sinus is infectious in most cases. Alveolar periostitis and erysipelas play a conspicuous role in the etiology. Carbuncle of the back of the neck is a rare cause. The symptoms, besides those of general sepsis and those due to the causal disease, are the results of disturbances in the circulation of the sinus, rarely unilateral, since the thrombosis soon extends to the other side. For the diagnosis, of chief importance are: The eye symptoms (exophthalmos, chemosis, paralysis of the eye muscles, especially ptosis, changes in the eye grounds from stasis), with pyemic temperature. Thrombosis of the cavernous sinus can be assumed as certain, when these eye symptoms are bilateral. An infectious thrombosis of the cavernous sinus is a disease which almost always runs a fatal course, although spontaneous healing does occur. A prospect of saving the patient's life is offered by early operation, which should aim at emptying the sinus itself. Because of the difficulty of gaining access to the sinus, one should be very cautious in its performance.

Pyloric Stenosis in Infancy.—Richter (*Surg., Gyn., and Obst.*, 1911, xii, 568) says that it is evident that the abundant literature on the subject that has developed in the last ten years is resulting in the recognition of this disease as a widely distributed condition. Two types are generally recognized—one characterized by a spasmodic action of the normal or slightly hypertrophied pyloric musculature, the other by an hypertrophy of the circular muscle of the pylorus, which enlarges to such an extent as to produce a tumor mass which effectually blocks the pyloric lumen, causing a mechanical obstruction. Richter uses the term "pyloric stenosis in infancy" in a general sense to include all cases; and limits the terms "spasm" and "hypertrophy" to the above-described conditions. The symptoms begin during the first weeks of life, usually in the second, third, or fourth. The first symptoms to attract attention are vomiting, constipation, and loss of weight. The vomiting is of a peculiar propulsive type. In one case the vomitus was thrown a distance of four feet. Vomiting commonly is accompanied by diarrhea. In pyloric obstruction it is accompanied by constipation.

With the vomiting and constipation are all the usual accompanying evidences of mechanical obstruction found in the adult—rapid loss of weight, profound depression, though not suggestive of the collapse of gangrene. With the diminished ingestion of fluids the baby presents the shrunken appearance of excessive dehydration. The urine is greatly diminished and finally almost totally suppressed. The upper abdomen is full, tense, and bulging, and is made more prominent by a marked retraction in the hypogastric region. The bulging mass is due to the distended stomach, made more evident by the collapsed and empty state of the bowels. In cases with hypertrophy, there can be palpated a small, solid, and very freely movable tumor, above and to the right of the umbilicus. Three types of operation have been widely practised—division of the pylorus, pyloroplasty, and gastro-enterostomy. Gastro-enterostomy has been the operation of choice of the great majority of operators, and was performed in the eleven cases operated on by Richter. There was one operative death, and of the 10 cases that recovered, one has since died. It was a typical hypertrophic stenosis. There is a universal gain in weight following the operation. None of the nine babies living shows any evidence of intestinal disturbance.

Concerning the Behavior of the Intestine under the Influence of the Digestive Activity of the Gastric Juice.—Fiori (*Zentralbl. f. Chir.*, 1911, xxxiii, 890) conducted a series of experiments on cats and dogs to show that the jejunal wall is not damaged in any way by contact with the gastric juice. He believes that the tissues of the intestinal wall contain an antiferment, which is capable of resisting the proteolytic action of the pepsin. The first series of experiments consisted in simply attaching the intestine to the stomach by a continuous seroserous suture, without opening the stomach. In the second series, a portion of the intestinal loop was laid in the thickness of the stomach wall between the mucosa and muscularis, without opening the stomach. In the third series the same operation was performed as in the second, with excision of the muscular layer around the attached portion of the intestine. In the fourth series the intestine was attached to the stomach as in the first series, but the stomach was then opened and the stomach wall was then excised at the site of the attachment of the intestine. This was to insure against the constriction of the intestinal wall by the muscular ring in the stomach wall. In the fifth series an excised portion of the small or large intestine, with good vascularity, was laid in a corresponding deficiency in the stomach wall. In none of the seven dogs operated on in the last series, which lived from two to thirty-six days after operation, was any change observed in the transplanted piece of intestine. This was a positive proof of the resistance of the intestine against the digestive activity of the gastric juice. While in the first series no disturbances arose from the simple attachment of the intestine to the stomach by the continuous seroserous suture, in the second and third series it was shown that the gastric muscle surrounding the attached intestinal loop can cause severe disturbances of nutrition, which may lead to necrosis of the tissues enclosed. In the fourth series it was shown that the intestinal wall, when not under the ischemizing influence of the gastric muscle ring, can resist the digestive